Virginia Department of Social Services
Medicaid Fact Sheet #11
QUALIFIED MEDICARE BENEFICIARY

The following information is given as a guideline only. In order to determine Medicaid eligibility, an application must be filed with the local department of social services in the area in which you live.

Congress enacted the Qualified Medicare Beneficiary (QMB) program as a mandatory program as a part of the Medicare Catastrophic Coverage Act of 1988. If you qualify for this program, Medicaid will pay your Medicare premiums, coinsurance and deductibles.

Generally, to qualify for the QMB program you must:

- be entitled to Medicare Part A.

- have countable income at or below the federal poverty guidelines for 2005. Income includes Social Security benefits, pensions, wages, interest, dividends, etc. Your countable income must be no more than $798 per month. If you are married and your spouse's income is counted, the limit is $1,070 per month. If your income is higher, you may be eligible for other limited coverage under Medicaid.

- not have countable resources in excess of $4,000 for one person or $6,000 for a couple. Resources are things such as bank accounts (checking, savings, certificates of deposit, Christmas club, etc.), stocks, bonds, cash value of some life insurance policies, property that does not adjoin your home, etc. Your home and adjoining property, one automobile, burial plots, home furnishings, property in which you have only a life interest, and personal jewelry are not counted as resources.

If you qualify as a QMB, you will not have to pay:

- the Medicare Hospital Insurance (Part A) monthly premium, if one is required. The monthly premium is $206 or $375 in 2005. Most people are entitled to Part A based on their or their spouse's employment and do not have to pay a premium. You must pay for Part A if you or your spouse did not work in Medicare-covered employment or did not work long enough (generally 10 years) to get premium free benefits. Among other things, Part A pays for care in a hospital or skilled nursing facility. It does not pay doctor bills.

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- the Medicare Part A hospital deductible that exceeds your Medicaid co-payment. The deductible is an amount a beneficiary must pay before Medicare starts paying. Medicare pays all other hospital costs for the first 60 days of each benefit period. In 2005, the deductible is $912 per benefit period.

- the Medicare Part A daily coinsurance amount for a hospital stay lasting more than 60 days. The daily coinsurance amount in 2005 is $228 for days 61 through 90 and $456 for each of the 60 lifetime reserve days a beneficiary uses when more than 90 days of hospital care are needed in a benefit period.

- the Medicare Part A daily coinsurance amount for covered care in a skilled nursing facility. The daily coinsurance amount in 2005 is $114 for days 21 through 100 in each benefit period. The first 20 days of covered care in each benefit period are fully covered by Medicare.

- the Medicare Medical Insurance (Part B) monthly premium. Part B helps pay for the services of doctors, other health care providers, and some medical services and supplies not covered by Part A. In 2005, the monthly premium is $78.20.

- the Medicare Part B annual deductible and coinsurance that exceed your Medicaid co-payments. The annual deductible is $100. Coinsurance is usually 20% of the Medicare approved amount for a service.

If you think you might be eligible for this program, you should file an application for Medicaid at your local department of social services. You do not need to visit the office to file an application. You can request that an application be mailed to you so that you can complete it and mail it back to the local department of social services. If you have questions or need assistance in completing your Medicaid application, contact an eligibility worker at your local department of social services.

MEDICAID FACT SHEET #11 QUALIFIED MEDICARE BENEFICIARY

FORM NUMBER - 032-03-828/22

PURPOSE OF FORM - The local agency worker may distribute this form to provide customers with basic policy information regarding this limited Medicaid coverage.

NUMBER OF COPIES - One

DISPOSITION OF FORM - One per inquirer.

INSTRUCTIONS FOR PREPARATION OF FORM - The form does not require the addition of any information by the eligibility worker.